MIHP Implementation Workgroup Meeting
April 12, 2006

Present: Dianna Baker, Ann Bianchi, Lynette Biery, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Brenda Fink, Judy Fitzgerald, Susan Gough, Bonnie (Ayers) Havlicek, Vicki Herron, Mary Ludtke, Deb Marciniak, Sue Moran, Jackie Prokop, Diane Revitte, Carolynn Rowland, Peggy Vandermeulen, Vanessa Winborne, Betty Yancey.

By phone: Sharifa Aboumediene, Soleil Campbell, Alethia Carr, Janine Chittenden, Patricia Fralick, Nancy Heyns.

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Absent: Mark Bertler, Belinda Bolton, Sandra Brandt, Suzette Burkitt-Wesolek, Sr. Barbara Cline, Sheila Embry, Sheri Falvay, Ed Kemp, Gary Kirk, Phyllis Meadows, Rick Murdock, Sonja Rashad, Paul Shaheen, Tom Summerfelt, Betty Tableman, Sharon Wallace, Darlene VanOveren, Jeff Wieferich.

Tasks

1. MIHP providers will tell Paulette if they would like to volunteer to test the new online 5As training module.
2. MIHP providers will tell Ingrid if they want to be on one of the Joan Bowman calls to discuss case management or if they have MIHP clients who would be willing to participate.

Taking the Tobacco Domain from Population Identification through Outcomes

Stacey Duncan-Jackson said that she was asked to explain one domain (tobacco) in its entirety, showing how the components (patient identification, screening/assessment, risk stratification, interventions, measurement, and outcomes) all inter-relate. Some key points that were raised during the discussion included the following:

1. Pat said that she still thinks we shouldn't define women who use a pack a day as low risk, especially since they tend to under-report how many cigarettes they smoke. Stacey noted that the Michigan Families Medicaid Project (MFMP) made this recommendation to DCH, but DCH has to decide if they want to go along with it or not, based on the literature and on the availability of resources. Lynette said that a nicotine exposure dose curve shows that more exposure leads to more bad outcomes. However, it's not a straight line - the potential for bad outcomes tends to accelerate at a pack a day, so that's where we decided to draw the line. There's no research paper that says this is absolutely where we should draw it. This will be the case with all of the domains – we have to make an educated decision based on the lit and resources. We started out with low, moderate, and high-risk levels, then we went to low and high. Lynette said we could think of low risk as moderate or just think of lower and higher, if it helps to use more relative terms. Bonnie said that local policy makers looking at this matrix will accept as fact that 20 cigarettes/day is low risk. Lynette said that in actuality, every Medicaid beneficiary is at least low risk due to poverty; maybe we should switch our levels from "no, low and high risk" to "no/low, moderate and high."

There was agreement on this. After a year of data collection, we may decide to lower the number of cigarettes that equates to moderate risk – it will be a tough decision due to resource allocations. Tobacco is the most clear-cut domain, but few women will have risk in this domain only. The algorithm will be such that a woman could score low in several domains but this would add up to high risk overall.

2. Stacey said that DCH asked her to draft a care plan that would reflect the matrix. She presented the draft titled, "MIHP Tobacco Domain Care Plan – Draft 1 (sdj 02-13-06)." She noted that this draft is very specific and that in the end, we'll probably land on a format that's between this draft care plan and the current care plan in terms of specificity. There will be room for individualized comments but the plan will include some kind of check-off for measurement purposes, as free-form narrative text is very hard to measure.
3. Judy said that some MIHP provider records are housed at offices with limited space for charts in the medical records department. If each domain has multiple pages, the size of the care plan would be prohibitive. Stacey said that it's long, but you would only see parts of it, because all interventions and intervention levels won't apply to every woman.
4. Pat said that the matrix indicates that we'll fax the (7-page) plans to OB providers, but our OB providers group says don't bombard us with unnecessary paperwork. Stacey said probably some kind of care plan would be faxed. Jackie said that our medical home subcommittee should address provider communications.
5. The tobacco intervention is 5As, which is based on readiness to change. IHCS and DCH are working with MIhealth.org to develop a web-based 5As training. Paulette said that the module is almost done, and to let her know if you would like to volunteer to try it. MIHP providers will be able to complete the training on their own time and we can easily update the module as needed.
6. The intervention matrix recommends pharmacological therapy if a pregnant woman is smoking heavily and can't cut back. At one point, the DCH Div. of Chronic Disease objected to this, but this has been resolved internally. If a medical provider determines it's appropriate, MA would pay for nicotine replacement or welbutrin. The literature is clear that if a woman is smoking above a pack a day and can't quit, the risk of pharmacological therapy is less than the risk of continuing to smoke.
7. We'll be measuring outcomes across domains and the measures on the matrix are a place to start. Measurement relates to the intervention and the desired outcomes. For some outcome measures there will be multiple data sources. We will use the discharge summary to capture data that we can't pick up elsewhere. Carolyn suggested that the number of cigarettes smoked pre and post could be tracked with checkboxes on the care plan rather than added to the discharge summary.
8. The tobacco domain says that providers will be calling the woman on a periodic schedule – other domains will also say this, but we don't expect providers to be making separate calls to discuss different domains. How providers will document follow-up when a woman has no phone is yet to be determined.

9. Bonnie noted that the focus of the tobacco interventions is women who are unready to change, but those who manage to quit need a great deal of support at that time to stay "quit." We're supposed to repeatedly visit or call women who are unready to change, but we can turn them off by continually contacting them to ask about their plan to quit smoking. Lynette agreed that if a woman is not ready to change, it isn't easy to motivate her, and that the case rate will give providers the flexibility to make these decisions. Heavy smokers who aren't ready to quit are to be referred to their medical provider for pharmacological therapy after 4-6 weeks of MIHP contacts because the risk of continuing to smoke during pregnancy is so enormous. Pregnancy sometimes offers a window for quitting, but it's hard, especially when a woman is at high risk in other domains too. There is some evidence that says you have to deal with her depression first. Isn't there data that shows that nagging doesn't work? Lynette said the intervention isn't in stone and we can we can look. It was suggested that we also look at data about what happens if we don't meet the women "where they are" and don't address the goals that they want to address.
10. Sue said that we should continue to provide input on these documents electronically.

MIHP Program Assumptions

The MIHP Steering Committee (SC) recently revisited the program assumptions to make sure we're remaining true to them as we work out the details of implementation, and made a few clarifications while we were at it. So we are asking the IWG to revisit them as well. Comments included the following:

#3. Peggy said that with respect to this item on using community resources, we need to be able to vary the team composition, including parapros.

 # 4 and #10. Pat noted that both of these assumptions say "MIHP providers cannot deliver interventions that are outside of their scope of professional practice" and wondered if new wording in these items meant we're moving to a non-professional model. Brenda said it means that we don't expect MIHP providers who don't have mental health or substance abuse treatment background to deliver psychotherapy or substance abuse services, if these services are not available in community. Lynette said MIHP is a support program, not a treatment program. Brenda said the language in #10 doesn't mean we are excluding paraprofessionals – it was to make the point that interventions should be relatively standard but there has to be a balance – we don't want professionals to lose their ability to use professional judgment. Lynette noted that we may need to tweak #9, which also gets at this issue of balance.

Carolynn said that with respect to the scope of practice, there are interventions we need to bring to our clients - we know if all we do is send them someplace else, the women won't get what they need. Brenda said that as we address the interventions under each domain, we'll be working at this. Sue Gough said she agreed with Carolynn; we make sure they get the basic teaching that they don't get from their OB. We want to be able to do the

teaching. Lynette said we don't want to lose this, but we will have to do it a little differently – for example, some women will want it over phone, not in the home. Jackie said: you're saying that you want to provide interventions, not just link women to other services. Pat agreed with Sue and Jackie. The tobacco care plan is not clear as to how these interventions could be done by phone. Pat is convinced that there must be an intervention component to get women to trust us enough to help them make changes. Also, providers could just say ok, I made two calls and that's it. Brenda said that performance-based contracting would encourage providers to do all they can do.

#4. Is this where participant ownership fits in? At past DWG/IWG meetings, we repeatedly promoted the idea that women should be involved in assessment and goal setting. Lynette suggested that we add this concept to #7. Mary likes the word "partnership" between the woman and the provider - if we don't start developing this partnership with the engagement process, we won't achieve our outcomes. Mary would put the partnership as Assumption #1. Lynette asked if we could make it #2, since somebody has to run the program! (The current #1 is about Medicaid and the Div. of Family & Community Health co-managing the program and supporting the people who serve the women.)

#5. Brenda said we need to keep reminding ourselves that everyone is "in."

#7. Peggy said we'll have one big intake screening to determine risks at the outset, but we will do repeat screenings (at least a shortened version) – add "periodically."

#14. Peggy said the evaluation will measure mother and child outcomes, not only process and input.

MIHP Provider Training

Brenda said we're trying to focus training on where we're at in the change process, so we think our next training should address case management (CM), as it is key throughout all of our interventions. Providers are used to their own versions, but what will CM look like as we bring more standardization to MIHP? Joan Bowman, RN, MPA, CCM, MSU College of Nursing, is a professor who has extensive experience working with a variety of CM models (e.g., community based, person-centered, etc.). A few of us met with her and think she would be good at facilitating a training on CM that would meet our needs. We're a short moment in our clients' lives - how do we use it to give them more self-reliance, motivation, supports, etc.?

We're looking at a day in June for a videoconference. The am session would feature Joan presenting on CM models, how they would address MIHP outcomes, administrative-level and client-level dynamics applied to MIHP, etc. The pm session would be small groups working with case scenarios with opportunities to hear from and comment on each other's work. We would hope to end up with program manual.

It's important that Joan learns more about CM in your eyes as she prepares for the training. So, over next month, we will set up 3-4 regional phone conferences (4-6 MIHP Program Coordinators per call) with Joan. During these calls, providers will be asked to describe their CM models, how they engage women now, how they access resources, etc., so Joan can tailor-make her training for us. We will expect her to share the results of these calls with us, so we can learn what appears to be working as begin to evolve our CM protocol, which will be based on Joan's discussions with you and best-practices in the literature. Tell Ingrid if you want to be on one of the Joan Bowman calls. Also, if you have MIHP clients who would participate, it would be helpful to hear how they experience CM.

Sue Gough said we also need to discuss outreach to engage high-risk women – we're all doing it differently. Carolynn said that those who need it the most avoid us the hardest, and that this is often a function of what we do – if we don't respect, value, care for, and put our own stuff aside, we'll never engage them. Pat said that engaging high-risk women goes back to partnering with WIC – stats show that high-risk women do come though WIC. Brenda noted that it's hard to access women through WIC in some locations. Peggy said that right now, there's no way to go to them and get reimbursed – this needs to be moved forward fast. She also said she has a good link to a web site on health coaches and statewide certification for them. She will forward it to Raquel. Carolynn said that the Michigan Regional Skills Alliance in Detroit has a DOL grant to develop a community health worker (CHW) program in partnership with community colleges and the health department to facilitate employment. Lynette said the MFMP advocates that adjunctive work should be done by CHWs, as there is a wealth of substance abuse and mental health literature showing that in order to find really high-risk women, you need to go to the streets and that the outreach workers need to look like the high-risk women they want to engage. Judy said that the CHW model is used very successfully in migrant camps to address medical care, substance abuse and mental health issues. Ingrid noted that the Spectrum Moms program also uses CHWs.

MIHP Work Plan Summary Review

Sue explained the MIHP Work Plan format. She noted that the various WGs will recommend policy documents to the Steering Committee (SC) and then the documents will come to the IWG. The Work Plan should provide a sense of the work happening now and the output that you can expect. It's updated periodically. A great deal of progress has been made. Some issues that were raised include the following:

1. We are getting close to talking with a vendor about developing the data management system/registry. The database will tell a provider if a particular woman is on WIC, MIHP, etc.; the screening data will be there.
2. Pat said that the Nurse Administrative Forum (NAF) feels that their input to the MIHP leadership is not being heard. Deb said that the MFMP prepared a document titled "MFMP Postnatal Screening Summary of Feedback and Recommended Response". Ingrid will put it on web site and send a copy to Pat to share with NAF. When Deb receives a comment, she replies that she has received

it and forwards it to the SC leadership. Periodically she summarizes the comments for the whole SC. Brenda said that we can't say we can always respond to every single comment but we reply to everything we can. If you have raised an issue that's important and you don't know what happened to it, go ahead and raise it again – we're taking comments as seriously as we can.

3. The screening evaluation has not yet been mailed out to providers.
4. Under "Future Activities" in the Work Plan, there's a place-holder for working on the case rate, pending completion of work on the interventions. You can expect more communication on the interventions and domains.
5. There is an educational WG (that will recommend educational materials across domains for all women, including no/low risk) and a medical home WG which should be folded into the prenatal care WG. Most of the WGs are not specifically named in the Work Plan.
6. Sue Gough said that the medical home WG had an interesting discussion about how MIHP providers coordinate with the health plans. They don't understand this piece – don't know what's in health plan contracts. Ingrid said that different health plans do different things and that the WG needs to discuss this further. Jackie said that providers don't know who to contact; there is an infrastructure and we need to tap people into it. Brenda said this is something Sue could help with or maybe this goes becomes part of our systems piece with Early On and DHS. Jackie said that Sheila is doing some work on communications between providers and the health plans too.